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# THE BRITISH JOURNAL OF DERMATOLOGY

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# BRITISH JOURNAL OF DERMATOLOGY

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THE BRITISH
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JULY, 1912.

## ROYAL SOCIETY OF MEDICINE.

### DERMATOLOGICAL SECTION.

### Special Discussion on Prurigo, Lichenification and Allied Conditions.

Meeting held on Thursday, June 20th, 1912, Sir Malcolm Morris, K.C.V.O., President of the Section, in the Chair.

It was decided by resolution to take as read the President's introduction of the discussion in the following paper.

The President opened the discussion by a paper upon "Prurigo, Pruriginous Eczema and Lichenification," since published in the *British Medical Journal*.* In a historical survey of the subject he pointed out that Hebra was not the first to describe the prurigo which is specially associated with his name. Willan had already described it under the name of *Prurigo agria*, and it was known to Cazenave, Devergie and other French writers as *Lichen agrius*. To Erasmus Wilson prurigo was simply a "pruritus associated with an organic change in the tissues of the skin," and its pathognomonic characteristic was the pruritus—"a pruritus without obvious or apparent cause." Wilson, therefore, did not distinguish between prurigo and pruritus, and dermatology is perhaps indebted to Hebra at least as much for his insistence upon this distinction as for his classic description of the severe form of prurigo known by his name. In limiting the term "prurigo" to a single, grave type of the affection, Hebra fell short of the truth, and Kaposi saw that his master had described only the grave variety of a disease which some-

* *Brit. Med. Journ.*, June 29th, 1912, p. 1469.

times manifests itself in a milder form, *Prurigo mitis,* not necessarily incurable, and showing no tendency to develop into the severer type.

French dermatologists questioned Hebra's contention that the papules precede the itching. Vidal preferred to style the prurigo of Hebra as a lichen. Besnier included among the prurigos many other itching conditions which he separated from the eczema group, qualifying them all as diathetic prurigos, provoked or maintained by an abnormal mode of nutrition.

Brocq defines three types of prurigo: (1) *Prurigo simplex,* with no eczematisation, the *Urticaria papulosa* or *strophulus* of other writers; (2) *prurigo of Hebra,* which may be either severe or mild; and (3) *prurigo ferox,* in which the papules are larger, the itching frightful, and the lichenification is less extensive than in the prurigo of Hebra. Darier includes among the prurigos Brocq's *névrodermites,* or *prurits avec lichenification.*

At the International Medical Congress in London in 1881 Mr. Morrant Baker exhibited three cases which were identified by Kaposi and the younger Hebra and Unna as types of the prurigo of Hebra, and this recognition is a landmark in the history of prurigo in this country.

The President next considered the ætiology of the disease and discussed the interesting speculations of Brocq, who finds in hereditary cross-breeding its true cause. Four influences are held to co-operate: (1) The neurotic condition of one or both parents; (2) lymphatism, either idiopathic or due to tuberculosis or syphilis; (3) auto-intoxications, originating in arthritism and aggravated by bad hygiene or by life in crowded cities; (4) chronic intoxications, in which alcoholism and caféism take the principal *rôle.*

The pathology, prognosis, diagnosis and treatment were next considered. Under therapeutics, early treatment was held to be of paramount importance. Good hygiene, generous diet, and cod-liver oil were essential. The itching should be controlled by baths medicated by starch, sulphurated potash, creolin or izal. The external use of cod-liver oil as recommended by Brocq was suitable in all stages, and to this beta-naphthol or carbolic acid may be added to control the pruritus. Carbolic acid ointment and various preparations of tar were also beneficial in rebellious cases, but their effects required careful watching. Complete occlusion of the surface, as shown by

some experiments of Jacquet, does not control the itching. Thibièrge has employed lumbar puncture in a long series of pruriginous dermatoses, but he was unable to draw any conclusions as to its benefit in severe prurigo. Sir Malcolm Morris looks upon radium and X-ray treatment as the least unpromising methods of treating intractable cases of this type.

*Pruriginous eczema*, in the opinion of the opener of the discussion, corresponds with certain of Besnier's diathetic prurigos. The lesions are of the most varied kind—erythematous, urticarial, papular, vesicular, impetiginous—with a preponderance of the urticarial element, and thus by almost imperceptible gradations they extend from eczema on the one hand to prurigo on the other. They differ from true prurigo in there being an antecedent history of eczema, by their running a less regular course, and by not being limited to the extensor surfaces, though these surfaces are most affected by the itching. There is, perhaps, no pruriginous affection in which the itching is more intense than it frequently is in this type of eczema. The condition may be due to disorders of the secretions, which so far defy detection, or to the influence of the nerve-centres, or changes in the nerve-endings in the skin, or to hereditary cutaneous irritability, or to microbic agency, or to a combination of two or more of these pathological states. The itching provokes scratching, the scratching sets up lichenification, which irritates the nerve-endings and sets up further itching, and the main object of treatment is to break up this vicious circle by reducing the lichenification and restoring the damaged tissues to their normal state.

*Lichenification.*—Lichenification, as Brocq says, is not pathognomonic of a definite morbid state, but rather a general process, which may develop without a preceding dermatosis, or may occur in the course of such dermatoses as prurigo, chronic eczema, pruriginous eczema, psoriasis, Psoriasiform parakeratosis, Pityriasis rubra, Lichen planus, certain artificial eruptions, and, according to Sabouraud, chronic streptococcal infection. Primary localised lichenification might be caused by friction or by contact with irritant liquids and secretions. The clinical features of the forms of lichenification were described, and the diagnosis, prognosis and treatment were discussed. The best results seen by the President in the treatment of lichenification followed the application of radium. The relief of the itching

was followed by great improvement in the general condition of the patients, the insomnia was relieved, and the weight increased.

The paper was summarised in the following conclusions :—

(1) That prurigo is a distinct papular affection, and not an urticaria, though in an early stage there may be difficulty in distinguishing it from that disease.

(2) That the term "prurigo" should be reserved for pruriginous affections presenting the characteristic papule and followed by lichenification.

(3) That for the avoidance of confusion the name of Hebra should be dropped out of the nomenclature of prurigo, and that the various types of disease should be qualified as *Prurigo mitis, Prurigo gravis,* and *Prurigo ferox.*

(4) That though prurigo usually begins in infancy, it may begin much later in life.

(5) That Prurigo mitis never develops into the severe forms of the disease.

(6) That the papule of prurigo may in some cases follow, and in other cases precede, the itching.

(7) That hereditary influence in the ætiology of prurigo is doubtful except as a factor in a family neurosis, and established facts do not appear to sustain Brocq's elaborate theory of a complex hereditary cross-breeding.

(8) That while prurigo is always an intractable affection, the prognosis in Prurigo mitis is not necessarily hopeless.

### Questions for Discussion.

(1) Should Hebra's name be dropped out of the nomenclature of prurigo ?

(2) Should the term "prurigo" be limited to affections presenting the papule described by Hebra and the subsequent lichenification ?

(3) Does prurigo begin as an urticaria ?

(4) Does the itching precede the papule, or the papule the itching, or is there no invariable order ?

(5) Is prurigo curable ?

(6) What are the best methods of treatment ?

(7) Why is not lichenification always a sequel of much scratching?

(8) Does the personal idiosyncrasy count for more or for less in lichenification than the influence of the pruritic affection?

(9) Is heredity a factor in the causation of lichenification?

(10) That pruriginous eczema, while true eczema and not true prurigo, is a link connecting eczema with prurigo.

(11) That lichenification may be either primary, as in the *névro-dermites* of Brocq, or secondary, as in prurigo, chronic eczema, psoriasis, Pityriasis rubra, Lichen planus, etc.

(12) That to explain the incidence of lichenification it appears to be necessary, in the present state of knowledge, to assume a predisposition either set up by the affection or pre-existing in the patient, or both.

Dr. Colcott Fox, at the President's suggestion opening the discussion, said he was very much interested in the President's remarks about what was a very important factor for the older dermatologists in the Section, namely the exhibition of cases of prurigo by the late Mr. Morrant Baker at the International Congress in 1881. At that date much interest was taken in these cases. In England at that time much confusion existed about the nature and diagnosis of prurigo, and nobody seemed to have very decided views about it. Mr. Morrant Baker brought up three magnificent cases, and at once Professor Kaposi, of Vienna, said "That is our prurigo." That made a great impression upon the younger men, and they forthwith set to work on a surer foundation to observe such cases in the future. The epoch was similar in importance to that in 1889 in Paris, when a case of Pityriasis rubra pilaris was shown, and long years of confusion ended by Kaposi saying "That is my Lichen ruber." With regard to the terms employed for these diseases, in the old literature much confusion existed between the terms "prurigo" and "pruritus." But one word which had been a standing source of annoyance to him was "pruriginous." He did not know whether that term arose from the French "prurigineux," but if so it was a bad translation. He did not know whether it meant a pruritic eruption, or one of the type of prurigo. In using such terms the user should be careful to define what he meant. The group prurigo was not common, but cases of it were met with from time to time. His experience was that, on the whole, it was a very well defined disease, and that it was fairly easy to diagnose, except under certain special circumstances, for instance

when all the skin was secondarily thickened with lichenification. When that was so it was impossible to make the diagnosis until the lichenification had cleared up. He had not found a necessity for dividing these cases up into any special types, though he admitted that one found marked differences. There was great variation in intensity and in duration. The disease might be life-long; on the other hand he had found it beginning later in life than one was formerly taught to expect, and it did not always begin in infancy. There were comparatively mild cases, and some cases were most intense. Widal established and individualised a special form which he called Prurigo ferox, but he did not remember having had a case of this. Besnier wrote a most instructive paper as a result of his experience, and that author seemed disposed to include prurigo in a great mass of eruptions in which the leading feature was, expressed shortly, toxæmias of various sorts. Lichenification, eczematisation and all sorts of eruptions occurred in the skin, and he, the speaker, thought it was too early to admit prurigo into such a vast chaos. He wished to say a word or two about the common disease known as Lichen urticatus, which was first described by our countryman, Thomas Bateman. It was a common disease and very interesting. The French school were now beginning to include it with prurigo, giving to it the name Prurigo simplex. He objected to the name "prurigo" for it, and the word "simplex" was a very inadequate qualification. The commonest elementary lesion was a central prurigo-like papule centreing in an erythematous red *tache*. He wished to remind the meeting that these lesions showed a strong tendency to become evolved late in the day and at night, and the *tache* portion was evanescent, so that in the middle of the day often only the papule persisted. Sometimes it was difficult to say definitely whether the condition seen was prurigo or not. In order to show how multiform this eruption might be, he mentioned that the red *tache* surrounding the papule might have in it a little serous exudation, not enough to vesicate, but to make the surface opaline, and it was called a wheal. The same thing occurred in Erythema multiforme, the papules taking on this opaline tint, when it was called Erythema urticatum. When the opaline character was there and a little more raising up and swelling existed it looked like urticaria. But that was not all, for in rare cases, especially involving the hands

and feet, the serous effusion might be so intense that bullæ, looking like pemphigus, might be formed. And even that was not all, for the central papulæ, under certain conditions, might vesicate also, and when it was surrounded by these red *taches* it was almost indistinguishable from varicella, and that was what Sir Jonathan Hutchinson called varicellar prurigo. It was true that this Lichen urticatus might come out after any constitutional disturbance—amongst other things varicella—but he had traced these so-called varicellar prurigo cases intermitting with the other typical forms, one week being of the common form, and next week the varicellar form. It was only one more stage for these vesicular central lesions to become pruriform, and then the characters were altered, and pustules occurred and crusting. He mentioned this because it was a multiform eruption with many phases, and he hesitated to include it under prurigo. And even if the term "prurigo" were applied, "simplex" in this connection was quite inadequate. He sometimes thought that the old disused term "strophulus" might be applied. There was much to be said in favour of Bateman's old name at the time that he gave it, for the lichen was the papule which he noticed, and there was urtication. He did not think it was getting much further to call it Prurigo urticatus. He objected to Kaposi's name "Urticaria papulosa," as also he did to the term "Prurigo simplex." With regard to lichenisation and eczematisation, all had followed with great interest what was said in the President's paper, and he considered it was a real condition, and what had now been written had cleared the ground of many difficulties in the study of skin disease. He agreed with all that had been said about secondary processes in the skin being peculiarly frequent in very inveterate cases of prurigo.

Dr. James Galloway said that he would do his best to conform to the strict regulations laid down by the President as to the limits of their discussion. The argument that he intended to bring forward as to the ætiology of prurigo might seem to be a little far-fetched, and it might be criticised as being an argument derived from simple analogy—not a good process of reasoning; but in regard to the difficult subject of prurigo and its allied skin-lesions, he was not aware that there was very much firm ground for argument other than those of analogy in the consideration of its ætiology. Making use of this method he wished to say that the disease of which he had had

some experience, and which most closely resembled the clinical aspects presented by true prurigo, using the word in the traditional sense ascribed to Hebra, was the very remarkable and serious pruriginous state occurring in certain cases of Hodgkin's disease—generalised lymphadenoma. In this condition it was well known that rarely nodules and plaques of the lymphadenoid tissue developed in the skin. Such a case was recently in the Westminster Hospital under the care of Dr. Hebb and Dr. Colcott Fox, which he (the speaker) had had the opportunity of seeing. In these cases little or no pruritus might be experienced, but in other cases of lymphadenoma, probably still more rarely, an eruption occurred, characterised by the most terrible pruritus; small papules made their appearance on the skin, the points of which were torn off by the patient, and the greatest exhaustion resulted from the itching, the restlessness and the merciless scratching and rubbing of the skin which were the consequence. Such a case in a woman had recently been under his care in Charing Cross Hospital, and he now presented a water-colour drawing, showing the characteristic features of this disease. The blood-crusted, intensely pruriginous lesions, the pigmentation of the skin and the enlargement of the lymphatic glands of the groin and the axilla presented a clinical picture simulating in a remarkable degree the severest cases of prurigo. Anyone seeing such a case for the first time might well say this was a disease very like true prurigo, but no more could be said at the present time than that the likeness was, perhaps, only apparent. In the case to which he alluded the disease was a true lymphadenoma, with pruritus of the utmost intensity and numerous prurigo-like lesions of the skin.

Such developments in the course of Hodgkin's disease were very rare, and true prurigo, also, in this country was very rare, so that the foundation of any argument based on clinical observation must be a small one. But after seeing such a case the thought could not help presenting itself that the pruritus of Hodgkin's disease so closely resembling prurigo, was probably due to the poison associated with the lymphomatous growth; in prurigo also a severe toxæmia existed, causing the papular lesions, the changes in the skin, the enlargement of the lymphatic glands, the pigmentation and its other phenomena. It was the custom to ascribe the causation of true prurigo to such influences as insufficient food, neglect of personal cleanliness, absence

of hygienic conditions of life. These might all produce severe forms of toxæmia, bringing about a very similar result to the toxæmia of Hodgkin's disease. It should be noted that the papular lesions occurring in the pruritus of Hodgkin's disease apparently did not consist of lymphadenoid tissue such as in the disseminated skin-lesions of that malady. The papular lesions of Hodgkin's disease seemed to be inflammatory in character. He considered pruritus and the lesions of the skin to be concurrent signs and symptoms of the toxæmic process.

He would like to say a few words on another subject raised by the President in his paper, namely, on the question of lichenification. He agreed that the processes underlying the changes, very roughly described as eczematisation and lichenification, were common to many diseases of the skin observed clinically. The President had suggested the question whether there was any hereditary or underlying tendency which made certain people especially prone to develop lichenification. His opinion was that the processes of eczematisation and lichenification were both probably associated with what one might call in a general way "septic conditions of the skin," meaning by that the presence in undue numbers of micro-organisms, possibly with their virulence in a low degree of development, but capable of producing inflammatory reactions. In eczematisation their pathological virulence increased and produced easily recognisable inflammatory changes. In lichenification, on the other hand, the process was not so acute, but stimulation of the skin by friction in any way might produce a certain degree of inflammatory thickening. He thought also that the persons liable to suffer in this way were those whom we loosely described as possessing seborrhœic conditions of the skin. The majority of such patients did not develop the well-marked manifestations of the disease, such as Acne vulgaris, to any noticeable extent, but the cutaneous surface harboured more bacteria than was normal, or, at any rate, had less resistance to those present.

Dr. Leslie Roberts (Liverpool) said true prurigo was very seldom seen in Lancashire, and what little he had seen of the disease had been in Vienna. He would like to echo part of the teaching of the great Hebra on the matter, and to beg that in taking views of prurigo speakers would not confine their attention to the lesions

merely, or to any special part, but look at the whole condition as a syndrome of, or as a group of symptoms, direct and collateral, by which one would gain a definite picture of a certain type of disease, a type which was certainly associated with very marked subjective symptoms, and which was followed by a lesion which, in itself, was not particularly characteristic. But there was one feature which he did not think they had quite sufficiently impressed upon themselves. It was what Hebra himself desired to impress upon his students, namely, that which presented certain characteristic details. If one looked at people suffering from prurigo it would be found that they were generally patients in the early periods of life, that they exhibited malnutrition, defective education, and they probably had a defective mental organisation. And when one stripped and examined the whole body it would be found that a very remarkable fact controlled the distribution of the disease. It was that the severity of the disease increased in proportion to the distance from the scalp. The lesions were very slight on the face, a little more marked on the trunk and the eruption became accentuated on the lower part of the abdomen more so on the thighs, and attained its maximum development on the legs below the knees. Having been taught in Vienna to pay attention to that fact, it appeared to him to be one of the most striking features in the clinical history of the disease. He would like to refer to the subject Dr. Galloway touched on, namely, lymphadenoma associated with pruritus. He remembered a case when he was studying under his old master, Sir Malcolm Morris, twenty-three years ago, that of a patient with lymphadenoma associated with intolerable pruritus. From his recollection of that case it did not tally with Hebra's prurigo; it presented none of the classical features of that disease. Therefore, he hoped members would have the matter clearly in their mind and not confuse pruritus and pruritic affections with that unfortunate name "pruriginous." Prurigo he believed to be a more or less definite type of disease. He did not lay very much stress on the subdivisions mitis, gravis and ferox, but he believed that the disease which Hebra described was more or less clearly defined, a definite simple type. Therefore he did not think one could dogmatise on this condition, because nothing was known about the ætiology, *i. e.* as to whether the pruritus preceded the lesion, or whether the lesion preceded the pruritus. All that could be done

was to trust their eyes, and seek all the aid possible from physiological chemistry and any other science which would help in the ætiology.

Dr. Whitfield said that he would first deal with the question of the diagnosis between the early stage of prurigo (Hebra) and that of Lichen urticatus. It appeared that no one in England at least was familiar with the former disease at its onset, almost all the cases having been in existence for some years when first seen by the skin physician. He had, however, rather lately seen a case in a boy in whom the disease had been present only about eighteen months and not in a very severe form. What struck him most was the marked pigmentation which was already present even in this mild and somewhat early case. He felt sure that he would have the members present in agreement with him when he said that it was not uncommon to see cases of Lichen urticatus which had persisted with very short remissions for a period longer than that quoted in this case of prurigo. Yet he did not remember that he had ever seen a case of Lichen urticatus in which diffuse pigmentation, other than that over recent scratch-marks, had existed.

Next he would turn to the symptom-complex which Sir Malcolm Morris had alluded to under the name of "pruriginous eczema." He believed that this was the disease which the French authors described as "*Prurigo à papules grosses.*" The disease was usually of very long standing and was extraordinarily refractory to treatment. As far as he was able to judge the initial lesion was a large papule about the size of a lentil, and consisted of a tense œdema. This was soon scratched, and exuded bloody serum which dried to a reddish scab. He had had for some years under his care a gentleman suffering from this disease who had also been under Sir Malcolm Morris, and whose tragic history he had often discussed with Sir Malcolm. When he had first seen this patient he had on several occasions examined his blood coagulation time and had invariably found it very slow. He had therefore given him doses of calcium lactate, with such marked success that the patient had written to him to say that he had found the cure. This was unfortunately not the case, and the benefit derived, though very striking, was not maintained. The patient went at one time to Llandrindod Wells, and again got so much better that his doctor there had written to Dr. Whitfield to say that he was quite

well. Again the improvement was not maintained and he became as bad as ever.

Some time later he came to London and was taken into a nursing home, and Dr. Briscoe worked at him very carefully by means of Joulie's phosphoric acid estimations. He was found to be very low in both acid and phosphates, and was treated with the appropriate doses until his balance approached the normal closely. This was associated with so much benefit to his health that all his friends remarked upon his appearance, though the actual itching was not equally improved. After a time he slid back into his old state and finally died of pneumonia. He had always been a sufferer from asthma. The history of this case and the temporary benefit derived from both calcium salts and phosphoric acid at different times was very striking, especially as those who had dealt much with blood coagulability and Joulie's method would know that, as Briscoe first pointed out, a low phosphoric acidity was almost invariably associated with a slow coagulation of the blood, and that the administration of phosphoric acid to these patients resulted usually in a hastened blood coagulation. Dr. Whitfield said that in the coagulation the influence of lime was only a reaction almost at the end of a long series of chemical changes. Nevertheless, there was no doubt that within certain limits they could influence the coagulation time by the administration of calcium salts. He thought, therefore, that upon some such lines as those introduced by Wright lay the future investigation of the obscure group of diseases under discussion.

Finally, he would like to allude for one moment to the eruption known as lichenification. He regarded it as a degeneration or premature senility of the skin. It was found most frequently where the skin became senile first or where it was exposed to continued trauma or infection.

If one looked at the back of the neck, a site of predilection for lichenification, in old people it was wonderful how wrinkled and rugose it became. This was probably the result of friction and constant movement. Again, the leg below the knee was peculiarly prone to early senility, and here again lichenification was frequent. It occurred also in the fork, but in this case it was probably more often the result of infection and the irritation of decomposing secretions. As regards treatment, he thought there was probably nothing so good

as X-rays. Of radium he had practically no experience as he did not possess sufficient of the body to treat large areas. He would point out, however, that the advantage lay with the X-rays on account of its superior rapidity, its being applicable to large areas at a time, and above all to the accurate way in which they could measure the dosage and therefore take up a very small amount of the patient's time.

Dr. Stainer said that when he diagnosed Hebra's prurigo he preferred, when teaching students, to see a generalised eruption, consisting of discrete, shotty papules, with plenty of blood-crusts and glandular enlargement. He had been in the habit of taking notes of the prurigo cases which he saw, and he could give notes of eight consecutive cases. Their ages were: A girl of four, a boy of six, two boys of nine, two boys of eleven, a man of twenty-six. In connection with the last of these he had the note: "Started at about fourteen years of age; no seasonal change, *i. e.* no difference at any time of the year. Never well; bad itching at night; glands normal." These normal glands at once sounded contradictory, and showed the difficulty of diagnosis. He agreed with Dr. Leslie Roberts that these cases were invariably the subjects of malnutrition, and were miserable specimens of humanity. The children seemed to get over the condition, as he had not seen it often in adult life. With regard to lichenification he would like to refer to the cases with single marginated patches. He took some observations on that condition, and he had a series of charts, about twenty in number, recording the distribution on the body, and the answers of the questions put to the patients. In three fourths of the cases the patch was either on the back of the neck or on the inside of the thigh. Where he got a definite answer to his question, it was always that the itching started first, and the rubbing produced the eruption.

Dr. Graham Little said that for many years he had taken an interest in prurigo, which he still preferred to speak of as the prurigo of Hebra, because one knew what that meant. It really did represent a clinical complex. His attention was first specially called to this disease by the difficulty he had in making a diagnosis between it and the disease Lichen urticatus, which he saw in such large numbers at the Children's Hospital, Shadwell. With regard to No. 3 of the conclusions set out on the sheet, he personally had not been convinced that one could distinguish between Lichen urticatus in children of a certain

age and the prurigo of Hebra. And his conclusion to that effect had been based upon the extreme difficulty which one experienced in getting a diagnosis expressed at meetings of societies, especially at the old Dermatological Society of London, where he showed many cases with the express object of finding out how the senior men would label certain cases. He concluded that no senior would commit himself to the diagnosis of prurigo of Hebra unless the disease had lasted a certain number of years in the particular patient. He could recall a number of cases, not commencing in infancy, in one of which the condition came on after an attack of scarlet fever in a child aged 6 years. The first case he saw was at St. George's Hospital, under Dr. Cavafy, who admitted the case, with a very learned note, such as Dr. Cavafy could write. The case came under the care of the Senior Physician of the hospital, who controverted the diagnosis, and said it was scabies. The case prospered exceedingly under the treatment for scabies, and a lecture was given on the case, ridiculing the dermatologist's diagnosis. But it was a case of the prurigo of Hebra, and the eruption returned shortly after the patient went out. From that experience it was evident that the main treatment was rest—in fact, keeping the patient in bed; nothing did so much good for Hebra's prurigo as that. He had known many cases which had been admitted to the wards without the diagnosis being made and which were greatly improved by the rest in bed. He was interested in Dr. Whitfield's remarks about the Julie methods; the administration of phosphoric acid was sometimes very valuable. He had satisfied himself that in many cases, not only of the prurigo of Hebra but in other similar conditions, the phosphoric content in the urine was very small, and the administration of phosphoric acid was very beneficial for the relief of the itching. With regard to Question 9, heredity, it was an extraordinary fact that of the cases of the prurigo of Hebra, not more than one case in ten was found in the British-born—the vast majority were in aliens. That was his experience at the East London Children's Hospital, Shadwell, where, of course, he had good opportunities for noticing that. He practically never saw the disease at his West End clinique at St. Mary's Hospital. He regarded the racial factor as a very strong one in the causation of prurigo. It was not always easy to differentiate between pruritic eczema and Hebra's prurigo. He had a case which he showed at the Dermatological Society of London ten years ago in

connection with which the subject was very much debated. That woman was still attending his department, and her eruption was in an unaltered condition. He could not yet make up his mind whether it was pruritic eczema or the prurigo of Hebra.

Dr. J. M. H. MacLeod said that he quite agreed that prurigo should be regarded as a distinct affection. He considered that Hebra's name rather complicated the conception of prurigo, as except in Vienna he had never seen a severe case such as Hebra described, and the cases which were generally met with here were of a much milder type.

In his experience prurigo was an exceedingly rare disease, and during the last five years in the Skin Department at Charing Cross Hospital and the Victoria Hospital for children he had only seen three cases, and they were of a mild type. Two were in young adults and one in a boy of ten years, in whom it had begun when he was about five years old. In neither of these hospitals were there many aliens among the out-patients.

He considered that it was doubtful if prurigo ever began in infancy, and that the disease which occurred in infants seemed to him to be papular urticaria.

Prurigo appeared to him to be a peculiar type of reaction of the skin, occurring in a predisposed individual, due to some toxin, probably of autogenous origin, circulating in the blood. In the first instance a toxin of considerable virulence might have been necessary to produce the reaction, but once it had occurred the organism became so sensitised that even slight defects in metabolism or functional derangements of some organ might lead to a fresh outbreak or exacerbation of the condition, till it eventually became a veritable habit of the skin called forth on the slightest provocation.

He believed that the question of the priority of the itching and the papule was almost impossible to decide, and that both appeared to him to be symptoms, the one objective and the other subjective, a common cause, and to develop about the same time. He did not consider that scratching or rubbing produced the papules in prurigo.

With regard to lichenification he believed that a special irritability of the skin was necessary, and that that might be the result of the presence of some itching disease like eczema, or be due to a peculiarly neurotic state of the patient. He agreed that alterations

in the skin from malnutrition, old age or disease might render it more liable to occur, but did not consider it to be essential. He believed that the itching preceded the lichenification, which was the direct result of rubbing. He also had obtained excellent results in the treatment of the affection with the X-rays.

Dr. Bunch: Even at a children's hospital so large as the Queen's Hospital for Children, where thousands of cases pass through the hospital in the course of a year, the number of typical cases of prurigo is astonishingly small when contrasted with the cases of urticaria. But on looking up the case sheets of such prurigo cases, it is found that on their first attendance a year or more previously, when the baby was quite small, a diagnosis of Urticaria papulosa was, as a rule, made. Indeed, I am not altogether clear as to the exact point at which a prurigo becomes a prurigo; one essential point seems to be that the disease must have already had a very considerable duration in the patient. Any method of classification or definition which tended to narrow the group of diseases which are now known as prurigo would, it appears to me, be welcome, and I am glad to see that the President proposes to exclude prurigo simplex and the *névro-dermites*. But I am not so satisfied to admit as genuine cases of prurigo those in which the papule precedes the itching. Such an admission will make it very difficult, if not impossible, to exclude from the prurigo group those cases of (originally) papular eczema which show well-defined lichenification, and how many cases of papular eczema which have existed for any appreciable time do not show lichenification? Thus, in the future, the cases diagnosed as prurigo will greatly increase in number and the cases of papular eczema will largely diminish. Especially will this be the case if it is admitted that prurigo may start late in life. I have copied out of the latest text book on skin-diseases, which I received only a few days ago, this sentence: "Some of the older writers have loosely applied the designation 'prurigo' to a variety of itching dermatoses." Modern dermatologists must at all costs avoid this pitfall.

Dr. Dyson (Manchester) said he did not know in what respect he could help the discussion. Very few cases of prurigo were seen in Manchester, for in the last three years he could recall not more than three instances of it, and the subjects in all these cases were foreigners. Two were children and one was an adult man. He did not think

papular urticaria was less common among the English than among foreigners; but prurigo was certainly mostly seen in aliens. He did not consider that one of these conditions led into the other; urticaria did not precede prurigo. In the case of urticaria the localisation was general over the whole body. The localisation in the cases of prurigo which he had seen was very definitely on the extensor surfaces, and that was not a peculiarity of urticaria. A question in the paper was: "Does the itching precede the papule, or the papule the itching, or is there no invariable order?" He did not see how that could be answered, because prurigo could not be diagnosed unless the papule were found, and the history was not reliable, because for it one had to depend on the statement of the patient. For lichenification to take place he thought it required some peculiarity in the skin of the patient. Though he could not say he agreed with it, Dr. Galloway had made a suggestion which deserved consideration, namely, that it might be the seborrhœic type of skin which was prone to lichenification. For lichenoid patches he agreed that the best treatment was by means of X-rays.

Dr. Douglas Heath (Birmingham) said he would like to thank the officers of the Section for having extended an invitation to a provincial colleague to take part in this discussion. He thought everyone would agree that a difficult subject had been most ably handled and its conclusions crystallised into shape by Sir Malcolm Morris. The ground covered by him was so very wide that he (Dr. Heath) should carefully avoid being drawn into the conflict of dermatological nomenclature inexactitudes, and should only briefly epitomise a few of his own impressions and observations. In the first place he had never seen Urticaria papulosa (Lichen urticatus) develop into prurigo mitis or gravis, and although severe cases of the former disease might closely resemble prurigo, he thought there were always points of difference present by which the two affections could be differentiated. The papule of prurigo was, he thought, nearly always more ill-defined and less superficially set than that of Lichen urticatus. It did not also so commonly present the yellow point or small vesicle on its summit, and the erythematous zone temporarily present in Lichen urticatus was commonly absent in prurigo. The extensor distribution was so well maintained in prurigo that he doubted if it was ever departed from in the mild cases, and it was always highly charac-

teristic in the more severe forms. Prurigo was essentially a regional disease. Urticaria papulosa was a disease of irregular distribution, and its effloresence was also variable within certain limits. In Prurigo gravis he believed most of the more severe manifestations were due to secondary pyogenic infections as a result of scratching, and his experience taught him that lichenification in this disease, like glandular swellings, could be largely prevented by efficient antiseptic treatment. He always used mercurial lotions and ointments himself, as he did in the treatment of impetigo. Itching in prurigo usually, he thought, began with the starting papule, but lichenification also he thought induced itching howsoever produced. With regard to the ætiology of prurigo, he should like to put forward the suggestion—speculative though it was, and the evidence in its favour perhaps only slender—that diminished sweating and sebaceous excretion was in some way the cause in certain types of children. There was no doubt that the skin in prurigo was dry and xerodermia-like. This moderately or severely lichenified skin when hot could obtain no relief for its tense blood-vessels. Everyone was familiar with the discomfort to patients of a non-sweating skin, and in certain persons this discomfort always caused severe itching, which was relieved when sweating took place. In extensive xerodermia, when sweating might be practically absent over large areas of the body, a prurigo-like eruption with deeply seated papules might be sometimes seen. Dr. Heath had several times seen this eruption, and there was no doubt from the scratching that took place that the disease was highly irritable.

In the children of the poor in large cities, washing, except of the face and hands, was often considered by the female parent a quite unnecessary and superfluous performance, and contact with soap and water was rarely indulged in. Added to this the clothes were rarely changed, and the skin had to carry on its functions against all these difficulties. Did it ever fail to do so, and, failing, did some other development follow? Miliaria from over-wrapping was familiar to all. Had prurigo a somewhat similar origin in a thickened skin, but deeper down? In chronic eczema dry thick papules, never going on to vesicles, appear from time to time, which, like those of xerodermia, resemble prurigo. Why does pilocarpine relieve this phase? Was it for the same reason that this same drug sometimes relieved prurigo? Why did thyroid extract sometimes do so, too? (Wolff

and others). How was it that prurigo practically never occurred in the children of the well-to-do, in spite of their patent food and chemist-shop diet? The children of well-to-do Jewish parents did not seem to develop the disease.

It might be argued that the dry, rough, non-sweating skin was the secondary condition in prurigo—but was it? Was not the papular eruption the *post hoc?*

Sweating was, Dr. Heath thought, generally more free on the flexors than on the extensors. If sweating failed it would probably first lessen on the extensor aspect of the limbs. In xerodermia this was certainly the case. Prurigo practically never attacked the axillæ or the bends of the legs or arms. Was it because sweating was so free in those regions?

Dr. Heath did not wish to maintain that internal causes, such as auto-intoxication, played no part in the ætiology of prurigo, but he suggested that an excretory failure—a dysidrosis—might exist with a failure in the elimination of some toxic bodies.

Did pathological findings in any way support such a hypothesis? Tavernier had found that the vesicles were in relation to the sweat-pore in prurigo, and Unna had observed proliferative changes in the vessel-sheath.

Lichenification did not always result from itching; it had been proved to follow pressure and friction on the skin. Lichenification when once set up caused and aggravated itching. Was excretory action—sweating, etc.—practically absent in lichenification? Dr. Heath thought it was.

Dr. G. Pernet said that Sir Malcolm Morris had summarised the complex and chaotic question in such a complete and excellent manner that he had included practically all that could be said on the subject. With regard to the prurigo of Hebra, Dr. Pernet had an opportunity some years ago (1897–98, *Derm. Note-book*, iv), when working with the late Dr. Radcliffe-Crocker, to keep under observation in bed in the hospital a very characteristic case of that complaint. Other cases had also attended the hospital, but owing to scarcity of beds they could not be taken in. In that particular case he repeated the work of Jacquet, wrapping up one arm and one leg alternately several times; and there was no doubt that in the covered limbs the papules did not make their appearance. So on that point

he considered Jacquet was right. He, Dr. Pernet, verified, to his own satisfaction at any rate, that the itching preceded the formation of the papule in that instance. The patient was a Jewish boy, and he agreed that most of these patients belonged to the Jewish race. But he did not quite agree with Dr. Leslie Roberts that these children were backward and stupid. This particular boy was very bright and sharp. He considered that prurigo of Hebra was a good name for it, and that it was a definite morbid condition. As a result of scratching it became very polymorphous. His object in speaking was mainly to insist a little more than the President had done on the prurigo or the prurigo-like eruptions of adults. These he designated for his own orientation as *Prurigos diathésiques* of Besnier. The point about these prurigo-like eruptions which began in adult life was their great multiformity. There might be various-sized papules, usually large, or vesiculo-papular conditions; or, again, lichenified patches or impetiginous complications, chronic furunculosis and so forth—that is, secondary infections. In one such case, though the furunculosis disappeared under vaccine treatment, the prurigo-like condition continued and made the patient's life a burden. In addition there might also be pigmentation, and that he regarded as an important appearance. The great point about these prurigo-like conditions was the intense pruritus, which, during the paroxysms, especially at night, drove the patient frantic; hence a vicious circle. In these patients there was not only a toxic condition, but also a distinct neuropathic soil. In women this *Prurigo diathésique* became more difficult to deal with after the menopause. He had never found in these cases any sugar or albumen in the urine, although he had made frequent examinations. Indican, etc., might be present. In one case, which he had under observation for some time, there was an alternation of asthma with the eruption on the skin (Case Book E., p. 190). Following upon beneficial treatment from the skin point of view the patient would have an attack of asthma. When the asthma subsided then the skin again became bad, and so on. He desired to call the attention of the meeting to a case which he had observed with the late Dr Radcliffe-Crocker, that of a man, in whom lichenification of the back of the neck had been followed by generalised true Lichen planus. Sabouraud appeared to think that streptococcal infection was the cause of lichenification. He, Dr. Pernet, had tried many kinds of

treatment in prurigo and the prurigo-like conditions. Thyroid did good; so also did phosphoric acid. He, like others, had tried calcium lactate without much result. One could not always induce patients to submit to lumbar puncture, which might give relief for a time, but unfortunately did not cure.

Dr. Adamson said that he held the view that Lichen urticatus of Bateman, prurigo of Hebra, eczema and lichenification of Vidal and Brocq were definite and distinct affections. They had been separated from the mass of pruritic eruptions after many years of patient observation, and he thought that to try to link them up by intermediate forms could only lead to confusion once more. He was not familiar with the eruption to which the name Prurigo mitis had been applied, and he did not know what was meant by pruriginous eczema. Prurigo might be complicated by eczema and so might lichenification, but he did not agree with Sir Malcolm Morris that there were eruptions which could be regarded as intermediate types or which formed connecting links between these quite distinct affections.

Dr. Sequeira said he thought the Society was to be congratulated on the masterly way on which the President had put the facts of this difficult subject before the Section. His own experience was that Hebra's prurigo was a very uncommon disease, and yet at his hospital, the London, there were many foreign patients. He always had cases of Hebra's prurigo about his clinique because he could not cure them, and they were practically all among other than British-born people. He could not add anything to the discussion as to whether there was urticaria preceding the formation of papules, or whether even the itching preceded the papules, because in these cases he had never had the opportunity of seeing the onset of the trouble. Moreover, the information he would be able to get from such a population would be quite valueless. With regard to lichenification, he looked up the notes of a dozen cases of lichenification which he had seen in private, in order that he might go very thoroughly into the causation. Six of the patients were males and six females. The ages of the former ranged between thirty-eight and sixty-one years, and of the females from forty-five to sixty-eight. The majority of the females were at about the period of the menopause. One case in a man was definitely the result of friction. He was not an obvious neurotic, but

he wore a waist-belt, and his patch of lichenification was in the middle of the back, the part constantly rubbed by the waist-belt. Two of the cases were apparently associated with prolonged chronic constipation. Another patient had had an attack following appendicitis, but removal of the appendix did not relieve the lichenification or localised prurigo, although such relief had been hoped for under the belief that the appendix was the cause of the chronic irritation, which had been very severe, and caused the parts to be torn. With regard to neurasthenia, overwork and nervous conditions following prolonged strain, he had one case in which the woman was worn out by rheumatoid arthritis—a very painful and prolonged case. Another was a patient whom the President had seen and whose nerves were shattered in the Boer War. That man had had recurring attacks of lichenification on the nape of the neck, always followed by a period of great nervous depression for which he was now constantly in the hands of nerve specialists. There were three cases of distinct overwork—two in men, one in a woman, a nurse. One of the men was directing a large railway system. In two of his twelve cases he could not find any obvious cause; there was nothing pointing to grave neurasthenia or a diagnosable nervous condition. He agreed that for the treatment of these conditions there was nothing to equal X-rays or radium. As most patches were of considerable size he preferred to use X-rays. He had been much interested in one or two remarks, especially those about gland enlargements and Dr. Galloway's reference to the association of prurigo with lymphadenoma. He had an extraordinary case in which the glands were very large in many groups, groin, axillæ, etc., and in which there was a remarkable papular eruption, which was so torn that he did not recognise it, and he thought it was a pruritic eruption associated with lymphadenoma. When he had the patient in hospital the case turned out to be one of severe Lichen planus and nothing else.

The President, in replying on the discussion, said his object had been fulfilled. The hour and a half had not been wasted, and it would prove to have been useful to hear the various points debated. With many of the things which had been said he agreed, from others he dissented. Among the latter was a remark by Dr. Adamson that the diseases discussed were separate and ought to be put into different boxes. He, Sir Malcolm, however, considered them as links in a

chain, which it was necessary to learn and appreciate. The older one got in the work the more one realised that there was no absolute subdivision, as was set out in text-books. One came to appreciate the fact that the labels decided upon did not always cover what was seen. Dermatologists were constantly seeing cases to which they could not give a precise diagnosis; such cases had been brought to the Society time after time, and yet no one ventured to give an absolute opinion. The facts were there, but the cases could not be labelled, because there were so many links. The motive in classifying certain diseases was to try to link them together. The term "pruriginous" had been criticised, but it was a matter of no moment to him what word was used. He did not agree with Dr. Galloway that these cases of lichenification were seborrhœic. He was aware that certain cases of seborrhœic dermatitis ultimately ended in lichenification, but a large group of cases in which there was lichenification did not begin as seborrhœa, and had nothing to do with it. They were nervous at the start, and began with itching, resulting in scratching. The reason was not understood. Even in old cases, where the skin had been badly torn, a cure was brought about by X-rays or radium, the latter for preference. Ordinary drugs did very little in true lichenification; something more penetrating was required to make the desired change.

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Clinical Meeting held on Thursday, June 20th, 1912, Sir Malcolm Morris, K.C.V.O., President of the Section, in the Chair.

Dr. Dore showed (1) a patient, aged 40 years, who presented a patch of *circumscribed lichenification* (*névrodermite*) in the right lumbar region which had existed for three years. The plaque showed the characteristic aggregation of glistening round papules, with a certain amount of thickening and slight pigmentation of the skin, but the three zones described by Brocq could not be differentiated. During the past four months the patient had had similar patches on the arms, thighs and legs, but these had recently disappeared. There was a generalised prominence of the follicles, especially on the legs, and the hairs were rubbed away by the con-

stant scratching. According to the patient's statement, the pruritus preceded the formation of the skin-lesions.

(2) A child, aged 10 years, with acquired *syphilis*, who presented a grouped follicular syphilide of fourteen days' duration on the trunk, thighs, upper arms and flexors of elbows. The lesions were most marked on the upper and inner aspects of the thighs, where they had recently appeared; on the trunk the eruption had begun to fade and closely resembled Lichen scrofulosorum. There was also a typical syphilitic leucoderma of the neck. The child had a chancre of the vulva, but the first thing noticed by the mother was an ulcer on the dorsal surface on the tongue, which appeared eight weeks previously. The fauces were also ulcerated and there were condylomata around the anus. The present eruption was preceded by a characteristic papulo-squamous syphilide six weeks ago. A younger sister, aged 5 years, had condylomata of the anus and lesions in the mouth one month before the present case was affected. Both children gave a positive Wassermann's reaction and spirochætes were found in the lesions.

Mr. Willmott Evans showed a case with *multiple scars* on the body and limbs, and partial destruction of the ears. The patient was a boy, aged 9 years. He had been in good health until he was a little more than two years old, and then small ulcerations began to appear; these were for the most part on the limbs, but some also occurred on the trunk. The ulcers were almost exactly symmetrical, and most of them were small, less than a quarter of an inch in diameter, but those on the trunk were larger, reaching nearly an inch in size. About a year ago ulceration began on the ears, at the upper part of the helix, and it had steadily progressed.

At the present time the child has no ulceration, but he shows a large number of small pale scars, slightly sunken, on the wrists and ankles especially, but on other parts of the limbs also. On the calf the scars are larger, and the same is true of the scars on the loins. The upper portion of each ear has been destroyed to the extent of about a quarter of the pinna, but the surface is soundly healed. Mr. Evans considered that the condition of the ears was not unlike the effect of Raynaud's disease, but that would not account for the scars on the limbs; these reminded him rather of Dermatitis gangrænosa infantum, but the symmetry and the situation of the

scars were against this diagnosis. The case was under the care of Dr. Harrington Sainsbury, and as it had been seen only the day before, there had been no time to apply a von Pirquet or Wassermann test.

Dr. SEQUEIRA was of opinion that the lesions were necrosing tuberculides.

Dr. A. M. H. GRAY showed a case of *? potassium iodide eruption*. The patient, a male, aged 40 years, suffering from pulmonary tuberculosis, developed a "lump" below the left angle of the jaw in September, 1911, and another below the chin in February, 1912, both of which were "opened" and matter escaped, but the wounds did not heal, and the skin around them became inflamed. He also noticed some "soreness" of the left leg which he thinks commenced at the end of April, but can give no definite account of the character of the lesion present. As the sinuses in the neck did not heal, during May, 1912, he took two bottles of Clarke's blood mixture, (each estimated to contain about 52 grains of potassium iodide), and soon after commencing this mixture further lesions developed on the face, the left leg became much worse, and spots appeared on the right leg.

When first seen on May 30th (he had stopped taking the mixture about one week previously) he was looking thin and ill; he had marked œdema of both lower limbs and abdominal wall and some free fluid in the abdomen. His temperature was raised between 100°–101° F.; he had dulness, weak breath-sounds, and râles at the apex of his right lung, and was spitting up a considerable quantity of thick purulent sputum. His urine was diminished in amount and contained a large quantity of albumen.

Below the left angle of the jaw and beneath the chin were two sinuses freely discharging pus, and the skin around them had the characteristic appearance of scrofulodermia. Three raised tumours, each about the size of a thumb-nail, were also present, one on each side of the chin and the third behind the sinus on the left side; each was sharply raised from the surface of the skin and surrounded by a red areola. On the surface of each was a greenish crust, which, when removed, left a red irregular surface from which small points of pus could be squeezed.

On the left leg below its centre was a pale red patch measuring

10 by 7 cm., which was made up of closely set nodules, each about the size of a threepenny-piece. These nodules had a smooth flat surface and were only very slightly raised; some were firm to the touch, others showed signs of softening, and one or two had ulcerated. A few scattered lesions of a similar nature were scattered round the patch and a few discrete lesions were also present on the right leg. In addition a few lesions of a different nature were present on both legs; these consisted of red papules the size of a pea surrounded by a paler areola and surrounding a hair-follicle; in some of these a superficial vesicle or pustule had formed.

During a fortnight's stay in hospital practically all the nodular lesions had broken down and given discharge to a thick brown-coloured material, cultures from which gave a mixed growth of *Staphylococcus aureus* and *albus*. Wassermann reaction was negative. No local treatment had been adopted except to the scrofulo-dermatous areas, which had been dressed with weak mercurial dressings, and the rash had been gradually clearing up.

The case was shown to get an opinion on the nature of the nodular lesions, as the exhibitor had not seen a description of this type of lesion in potassium iodide dermatitis; the tumour-like lesions on the face and the vesico-papular lesions on the legs appeared to be well-recognised types.

Dr. WHITFIELD said that when the man first came he thought it was possibly a case of glanders by the general aspect. He did not now doubt that it was tubercular.

Dr. GRAHAM LITTLE showed for the second time a case of *Erythema multiforme?* which he had brought before the Section in February last. The condition had persisted very much as it had then shown itself, and the report then presented (*Brit. Journ. Derm.*, March, p. 119) was still accurate. Seeing Dr. Pringle's case, shown earlier in the present meeting, he was struck with the resemblance in configuration of the patches which both these cases showed, but in Dr. Pringle's case there was apparently no vesication, which was a marked feature in this patient. If the diagnosis of Erythema multiforme was accepted, it was certainly very remarkable that the individual lesions had persisted, as these had done, certainly for some

months, and that the disease had been constantly present, or nearly so, for three and a half years.

Dr. PERNET said he still considered the case was one of Lupus erythematosus. When the patient was first shown the iris aspect was characteristic and he then classed it as Lupus erythematosus iris of French writers. There was not always atrophic scarring in Lupus erythematosus in its early stages. To his eye and touch the present condition did not suggest Erythema multiforme, but Lupus erythematosus of an unusual type. The latter disease varied greatly in its appearances. Atypical instances need to be considered. He took the present case on broad lines. He hoped the exhibitor would be able to keep the patient under observation and show her again from time to time.

Dr. WHITFIELD pointed out that there was no sign of scarring left by the disease where it had been, although she had had it for a long time. In a case like this that was neither infiltrated nor atrophic he did not think that the diagnosis of Lupus erythematosus was justifiable. Moreover this disease left a considerable amount of pigmentation, which was not common in Lupus erythematosus but quite frequent after Erythema multiforme.

Dr. MACLEOD showed *a case of Xanthoma tuberosum multiplex* associated with peculiar osteo-arthritic changes in the joints in a man, aged 42 years. He demonstrated the case previously at the Society in June, 1910 (see *Brit. Journ. Derm.*, 1910, vol. xxii, p. 267). Since then he had seen the patient at irregular intervals, and his condition had not materially changed since he was first exhibited. The disease appeared to have made definite progress; his general health, however, had remained good except for occasional attacks of bronchitis; there was still no marked swelling of the liver or jaundice, and the urine did not contain sugar, albumen, or excess of urobilin. The eruption was more extensive and the swellings somewhat larger.

Since he was first shown a microscopical examination had been made, and as a result of the study of a considerable number of sections stained in different ways, the exhibitor had come to the conclusion that the earliest changes took place around the blood capillaries about the subpapillary layer and beneath it, and consisted of a cellular proliferation and an infiltration of the lymph-spaces between the fibrous bundles in the neighbourhood with a fatty substance which is easily stained with Sudan III, and readily breaks up into crystals of cholesterin and fatty nodules. This fatty substance is present in the cells around the blood-vessels as well as in those of the endothelium lining them. Owing to the presence of the fat certain of the cells became enlarged and the nuclei divided

to form the characteristic xanthoma giant-cells, with two or three nuclei to a dozen or more. The presence of the fatty substance appeared to act as an irritant which caused a proliferation of the fixed cells with the production of fibroblasts which gradually became organised into new fibrous tissue. In the earlier stages the cellular elements predominated, while later the fibrous changes were the most marked feature in the histology. The most important part of the fatty material is known to be a lipoid named cholesterol-fatty-ester. This is believed to be originally in the blood, and has been found there in jaundice and in diabetes. It would seem to pass out of the blood capillaries of the skin so as to infiltrate the lymphatic spaces and the cells. It has been suggested that the reason why this affection occurs most readily about the joints is that there the blood-vessels are subjected to a special strain, owing to the movements of the joints, and more blood flows through them. An interesting paper on this subject will be found in the May issue of the *Journal of Cutaneous Diseases*, 1912, by Pollitzer and Wile.

Dr. G. Norman Meachen and Mr. F. L. Provis showed a *case of Alopecia areata et totalis* cured by pregnancy and relapsing with the re-establishment of the menses. The patient was a well-developed but somewhat pale woman, aged 31 years. She had been eight years married, having had four children and two miscarriages, one of which was a still-birth. Her youngest child was ten months old when seen at the Blackfriars Skin Hospital, whither she was sent from the Chelsea Hospital for Women. She had had no previous illnesses, except anæmia when a girl, and there was no history of premature or other variety of baldness in any of her relations. In the sixth month of her second pregnancy she first noticed her hair beginning to fall, and when the child was five months old she "hadn't a hair in her head." During the third pregnancy, however, it began to grow again, nearly all of it coming back. Then the still-birth occurred, and when her periods returned the hair fell again, this time totally, other parts of the body besides the scalp being denuded. She became pregnant again, and from the first month of this pregnancy *the hair began to return*, and at this time, she states, she "had a splendid crop of hair, except two small patches." This was on June 2nd, 1911. When her baby was five months old the menses reap-

peared, *and once more the hair began to fall.* Her finger-nails became affected about the same time as the initial loss of hair. The special senses have, apparently, always been normal. All her children have been brought up on the breast, but not for an undue length of time. The bowels are habitually costive.

On March 26th, 1912, the whole scalp was practically bare, except for a few scanty strands of rather dark, coarse hair. The eyebrows were completely absent and there were no eyelashes. The remaining parts of the body were not absolutely alopecic. All the finger-nails were lustreless, longitudinally striated, and presented numerous fine pits, especially upon the lunulæ. The toe-nails were similarly affected, though to a less extent. The integument of the scalp is freely movable upon the bone, and it is not cicatricial in any degree. At the nape of the neck are a few erythematous macules, which, she states, "have been there for a very long time." The patient has the characteristic facial expression commonly seen in total alopecics. Several "point-of-exclamation" hairs were seen. These could be extracted with ease, and presented the usual appearances microscopically. The long black hairs that still remained broke off close to the scalp on pulling them, and did not come out by the root. The patient was attending the Chelsea Hospital for prolapsus uteri. At the time of the meeting the scalp was totally bald, and the other parts of the body were also denuded. The Wassermann reaction had not been taken. The patient had no signs of syphilis.

Instances of loss of hair during the puerperium as a result of the debilitating influence of parturition are, of course, well known, but that pregnancy and delivery should act as a tonic, as it were, to the growth of hair upon two successive occasions, alopecia supervening in between, appears to the exhibitors to be unique. At any rate, they have been unable to find records of a similar condition in dermatological or gynæcological literature.

Dr. PRINGLE suggested that the word "cured" was rather unfortunate in this case. He would prefer to say that she got well during pregnancy and was bad at other times.

Dr. SEQUEIRA said he had seen several cases in which there had been complete loss of hair after delivery. He had at the present time one woman under care who had completely lost her hair on three occasions. The hair grew between two pregnancies, but after the third the loss of hair was permanent. For some years he had been unable to restore the growth. He had under care

another woman who had complete alopecia after delivery, affecting the whole of the body. Her hair was now coming back twelve months after delivery, but there were areas in which the hair had not grown.

Dr. Leslie Roberts (Liverpool) said he had had a similar case in his experience recently. An unmarried lady was under his care some years ago with almost total Alopecia areata of the scalp. In course of time she got married and a few months later became pregnant, and while pregnant all the hair came rapidly back. After the twins were born she came to him, and though he examined the scalp all over with the lens it would have been impossible to have said she had ever had alopecia. The hair was vigorous and strong and remained so for a few months, and then began to fall out again. He thought that the connection between pregnancy and the recovery from alopecia was more than a mere coincidence, but what the connection was he could not say.

Sir Malcolm Morris and Dr. Dore showed a case of *ichthyosis* with late development. E. F—, aged 14 years. *Family history:* The father in good health but said to be highly nervous. Mother has been subject to attacks of eczema since the age of fourteen. She has always had a dry skin, especially of the hands and feet, and is also said to have had psoriasis. One sister, aged 4 years, is stated to be nervous but in other respects healthy, and her skin is smooth. Another sister died of a nervous complaint at the age of one month.

*Personal history.*—The patient was born with a smooth skin, but when she was three or four months of age her mother remembers consulting a doctor on account of roughness of the skin of the child's legs. This roughness has persisted until the present time. The patient is a delicate-looking, nervous child, but her general health is good. She has suffered from measles and other childish complaints and has had adenoids removed.

*History of present condition.*—The present condition was noticed three years ago when the skin of the abdomen became discoloured and the mother noticed small "dirty marks" on the front of the abdomen, which gradually enlarged and spread upwards to the chest.

*Present condition* (June, 1912).—The front of the chest is principally affected, and there are symmetrical, pigmented, roughened patches of skin above the breasts on both sides, semilunar patches below each breast and a circular patch above the umbilicus. The skin of these areas is papulated as well as deeply pigmented, and the surface can be peeled off, showing white skin beneath. The skin of the arms and legs is roughened by enlarged and slightly reddened follicles and that of the back and thighs is also rougher than natural. The palms are

rough and the natural lines of the skin accentuated. The knees are also slightly affected. The patient perspires freely. There is no itching, and she does not suffer any great inconvenience from her complaint.

Dr. Pernet pointed out that there was a certain amount of wart-like development, which he considered brought it into the nævus category. He did not consider that Ichthyosis hystrix was the same condition as ichthyosis. Ichthyosis hystrix was a nævus.*

Dr. J. J. Pringle brought forward a case which he ventured to diagnose as an example of the rare condition termed *Urticaria perstans annulata et gyrata*. The patient was an intelligent woman, aged 42 years, who was sent to him on January 25th by Dr. Haines, of Dartmouth Park Hill. She had been seen by him for the second time on the morning of the meeting. The disease was stated to have begun about Christmas, 1910, as "a severe crop of ordinary nettle-rash with white bumps," in which no cause, either external or internal,

* *Vide* Pernet, "A Note on Ichthyosis hystrix," *Brit. Journ. Derm.*, vol. xxiii, 1911, p. 332.

could be discovered. She was in perfect general health, her bowels were acting freely and regularly, and she was taking no drugs. No dietetic irregularity could be traced. The white "bumps" had become pink, and the eruption had persisted, although with altered characters and in greatly increased abundance, till the date of her first consultation. It was then noted that she presented a very unusual rash, copiously and pretty symmetrically distributed over the trunk, arms, thighs, and legs. The face and hands were unaffected. The primary lesions were tense, hard, œdematous, bright pink nodules projecting rather abruptly from the general skin surface and surrounded by a marked pale, "white" areola. They varied in diameter from a threepenny-bit to a shilling, but the larger nodules showed some central depression, and by their peripheral extension much larger circinate lesions were formed, the edges of which were raised, hard and œdematous, while their centres (by comparison) were sunken and pigmented. When these circinate lesions attained the size of about a florin their margins broke up, so that the largest lesions were mostly reniform, not completely circular. The lesions were so

abundant and so "fixed" in type that the possibility of a premycosic condition irresistibly suggested itself. The early manifestations of the disease were stated to be accompanied by sensations of stinging rather than of itching. This case was at first labelled provisionally an unusual persistent Erythema multiforme.

The patient was prescribed free purgation with salines, some dietary restrictions, and salol in ten-grain doses taken three times daily. She was subsequently given doses of hydrargyrum cum creta twice daily and occasional small doses of arsenic by Dr. Haines.

At her second visit, on the morning of exhibition, it was noted that the eruption had diminished to a remarkable degree, leaving no textural changes in the skin. The lesions which remained presented the same characters as before, and the pronounced zone of pallor round the lesions, both recent and of older date—indicating persistent vascular spasm—was as prominent a feature as before, and influenced the exhibitor in reconsidering the condition as a persistent urticarial rather than an erythematous one. This view received support also from the patient's repeated and decided statement that the rash had begun like a nettle-rash, which was always worse at the menstrual periods. She also asserted that the larger patches existed for about two months, and then completely vanished. Facticious urticaria was easily evoked, but to no unusual extent. The blood and urine had, unfortunately, not been examined.

Dr. Pringle had never seen a precisely similar case, and the only literature he had the hurried opportunity of consulting was the recent exhaustive article on urticaria by Dr. Colcott Fox in Clifford Allbutt's *System of Medicine* (vol. ix, p. 214 *et seq.*). Mention is there made of cases in which "certain wheals may persist an unusually long time, and that in rare cases the majority of the wheals may do so." To this category the case appeared to belong, and this, despite Dr. Fox's wise reservation that "the persistence of a wheal is so contrary to the usual temporary character, that we rightly assume a critical attitude in accepting an Urticaria perstans." He continues: "Many cases, however, have been recorded and secondary changes have been described as fibrosis, verrucosity, etc., Boeck relates a case in which they persisted *for three months*, and disappeared under the administration of sodium salicylate, without leaving pigmentation." Dr. Fox further cites such past masters in

observation as Kaposi and Duhring, who "hold that the wheal is capable of eccentric expansion, like a ringworm or E. multiforme; and in such cases ringed lesions may be produced (U. annulata, gyrata), the usual figured patterns being formed by intersection of the curves." With this very infrequent type of disease the exhibitor thought his case undoubtedly accorded.

Dr. Colcott Fox said there were several points of interest about such a case as this, points which did not favour the making of a firm diagnosis. The duration of the patches was a long one for a case of evanescent urticaria. With regard to the diagnosis from Erythema multiforme, a phase was described as Erythema urticatum where some serous exudation existed, but not in sufficient quantity to cause vesication, but which made the surface opaline. In certain cases of erythemata there was an urticate look. He was interested in the question whether true urticaria ever produced serpiginous lesions.

Dr. Graham Little considered that the case was practically identical in appearance with one which he showed himself two months ago, and which he hoped to show again that afternoon. It had been diagnosed by some members as Erythema multiforme, and by others as a cross between that and Lupus erythematosus, and by still others as the latter condition. The lesions had remained ever since he showed her, and they occupied much the same position as in this case, though they had definitely vesicated. He asked whether there had been vesication in this case. He did not regard this case as Erythema multiforme.

Dr. Pernet said he considered Dr. Pringle's case was an Erythema multiforme gyratum.

Dr. Adamson thought the diagnosis of Granuloma annulare ought to be considered. The firm, raised rings were very suggestive of those of Granuloma annulare. They were made up of a "necklace" of closely set nodules as in that affection.

Dr. Pringle, in reply, said the condition undoubtedly came out at first as "a white lump." Afterwards there was a central red prominence and a white halo round it. The close resemblance to Granuloma annulare had been recognised by the exhibitor, but negatived by observation.

Dr. Sequeira showed two cases of *Pityriasis rubra pilaris*.

(1) Annie I—, aged 35 years, a laundress, had suffered from the disease since she was fourteen years of age. The family history was unimportant and the patient had had no serious illness. She stated that the eruption first appeared on the face and spread to the neck. The eruption entirely disappeared each spring until this year, but this spring it got worse, invading not only the face and neck but also the limbs and trunk.

When shown at the meeting the scalp was covered with thick scales, but the hair had not fallen to any great extent. The face and neck

were covered with a diffusive scaly eruption. It was of a pinkish yellow tint in the face, the surface being covered with large adherent scales. On the chest, abdomen and back the skin was studded with closely set, acuminate red papules capped with adherent horny plugs and scales at the mouths of the hair-follicles. The individual lesions varied from a pin's head to a lentil in size, but the majority were small. The characteristic rasp-like feel of the skin was best marked on the back and chest. A similar condition affected both the upper and lower limbs, the nutmeg-grater-like surface of the upper arms and thighs being very obvious to the touch. The fronts of the legs were the parts least affected. The dorsal aspects of the skin over the proximal phalanges of the fingers presented groups of well-defined horny papules seated at the hair-follicles. The palms and soles were dry and scaly. The nails at their proximal parts showed some dystrophic changes. There was no evidence of visceral disease.

Von Pirquet's and Moro's tuberculin tests were negative. The urine was normal.

Blood examination: Leucocytes, 7400; polynuclear neutropils, 56·5 per cent.; polynuclear eosinophiles, 6·0 per cent.; small lymphocytes, 22·5 per cent.; large lymphocytes, 6·5 per cent.; large hyaline cells, 8·0 per cent.; coarsely granular basophile cells, 0·5 per cent.

There was slight eosinophilia and some excess of large hyaline cells and a slight diminution of the neutrophile cells.

(2) Florence C—, aged 6 years. This little girl presented a more severe type of Pityriasis rubra pilaris. She had had three previous attacks, which usually began in April. The starting-point in her case was behind the ears. The present outbreak began six weeks ago. The face was covered with thick yellowish adherent scales producing a mask-like appearance. The scaly condition extended over the neck and chest and back. On the abdomen, legs and arms the lesions were essentially follicular, the hair-follicles being red, raised and prominent, and capped with a horny plug or scale. The palms and soles were dry and scaly, and the scalp was covered with thick, rather adherent scales. The eruption was almost universal, but the fronts of the legs and the fronts of the forearms were the least affected. The urine was normal and there was no evidence of visceral disease. Von Pirquet's and Moro's tuberculin tests were negative.

The blood-count was remarkable: Leucocytes, 5400; polynuclear neutrophiles, 23 per cent.; polynuclear eosinophiles, 8 per cent.; small lymphocytes, 41 per cent.; large lymphocytes, 26 per cent.; large hyaline cells, 1·5 per cent.; coarsely granular basophile cells, 0·5 per cent.

The polynuclear neutrophiles were less than half the normal, the eosinophiles were high, but the remarkable feature was the enormous increase in small and large lymphocyte cells. There was no evidence of glandular affection, and it is difficult in our present knowledge of the disease to determine the significance, if any, of this blood-count.

A biopsy has been made in each case, and the horny layer of the epidermis was found thickened and considerably heaped up around the mouths of the hair-follicles. These were dilated to form cups which were full of horn. In this horny material there were some sections of small hairs as seen in specimens stained by hæmotoxylin and eosin. There was no alteration in the rest of the epidermis. The sweat-glands were normal and the dermis appeared unaltered. There was no cellular infiltration.

Dr. Adamson said that the younger patient shown by Dr. Sequeira had been previously under his care and that he had exhibited the case during a previous attack in May last year. Photographs were published in the *British Journal of Dermatology*, June, 1911. He wished to draw attention to a point of interest, namely, that during an interval between two attacks of what were typical Pityriasis rubra pilaris the child had had an outbreak of typical psoriasis upon the elbows and knees and elsewhere. When this case was exhibited last year Dr. Adamson had recalled the circumstance that Dr. Whitfield had previously shown a case in a child, aged 4¼ years, which at one time resembled follicular psoriasis and at another time was typical Pityriasis rubra pilaris. Dr. Graham Little had also mentioned a case of Pityriasis rubra pilaris in which the sister had psoriasis. The speaker believed that there was a very close relationship between Pityriasis rubra pilaris and psoriasis, and it was sometimes difficult to know whether a case was one of follicular psoriasis or of Pityriasis rubra pilaris.

Dr. Sequeira also showed a case of *solar epitheliomatosis* (late Xerodermia pigmentosa) in a man, aged 33 years. The patient had been shown before the Dermatological Society of London seven years ago. Since boyhood he has had pigmented spots and warty growths on the face and the backs of the hands. He now presented the appearance characteristic of Xerodermia pigmentosa, permanent freckles, numerous pigmented warts, depressed cicatrices where the warts had dropped off, telangiectasis, and also the scars of several operations for

epithelioma. He had been under Dr. Sequeira's care off and on for several years, and numerous epitheliomata had been removed. These, on section, showed characteristic cell-nests. The patient's general health has been good, and at no time has there been any involvement of the lymphatic glands. He is an agricultural labourer, and the development of the lesions is most rapid in the early summer.

The PRESIDENT asked what was the age at which these cases generally passed from the pigmentary stage into the papillomatous. He recently saw a case from a South Wales town in which the pigmentary stage lasted from early childhood and the papillomatous stage did not begin until after puberty.

Dr. PRINGLE said he had one case in which the disease began in the first six or seven months of life. The child was the daughter of a nurseryman, and had been allowed to lie a great deal in the sun. At three years of age it had already developed epitheliomata.

Dr. PERNET said he remembered Dr. Pringle's case quite well, as it came under his own care afterwards. He had demonstrated that the large tumour between the eyebrows was epitheliomatous.* Dr. Pernet had lost sight of the case for many years now.

Dr. WHITFIELD showed (1) a man, aged 62 years, suffering from *generalised sarcomatosis.*

The history showed that there had been a tumour of the eye three years before for which an enucleation of the eyeball had been performed. Details as to the nature of the tumour were wanting, but it was known that the growth was of a malignant nature.

Eighteen months ago a swelling had appeared over the angle of the jaw on the right side and this was followed not very long afterwards by the appearance of another over the front of the chin, and subsequently at frequent intervals by numerous others until the present condition had been reached.

The original tumour over the right angle of the jaw was at the time of exhibition about the size of a bantam's egg. It was entirely subcutaneous and there was no discoloration of the skin over it. On the chin was another large tumour of about the size of a greengage. This was adherent to, and partly actually in, the skin, which was reddened and pitted like the peel of an orange. Scattered thickly over the body, back and front, and more sparsely over the arms and thighs were numerous other tumours varying in size from that of a

* *Vide* Pernet, "Histology of Xeroderma pigmentosum tumours." (British Medical Association, Manchester Meeting—*Brit. Med. Journ.*, 1902.)

bean to that of a half plum. Some of these tumours were subcutaneous and had not affected the colour of the skin over them; others had involved the skin and turned it a peculiar bluish-red colour. None showed any sign of pigmentation, though it was probable that the growth was of the melanotic type. The hands and feet were quite free.

There were numerous nodules in the liver, which was considerably enlarged, and there were a good many symptoms of alimentary disturbance.

Dr. Whitfield said that he had seen the patient only once before, by the kindness of Dr. Norman, but that he proposed to take him into hospital and see what could be done for him by means of the X rays and possibly by the injection of salvarsan.

(*Note.*—Since exhibition the patient wrote that he would not come into hospital as another doctor had guaranteed to cure him.)

Dr. Graham Little recalled to the Section the case shown by him at the meeting of November, 1910 (*Brit. Journ. Derm.*, vol. xxii, p. 387), in which there was reason to regard the sarcomatosis as being primary in the skin. The patient, a young man, aged 25 years, had been admitted to St. Mary's Hospital shortly after being shown, and on the suggestion of Sir Malcolm Morris was given large doses of arsenic in the form of soamin injections (ten grains twice a week). Under the treatment the lesions had become markedly diminished in volume, but the man had suddenly died with symptoms, confirmed by post-mortem examination, of general acute œdema of the tissues of the throat and neck.

Dr. Wilfrid Fox said that the case he showed with Dr. Ashton Warner about eighteen months ago was somewhat similar to this. In that case they made a biopsy, but the histological structure was not at all characteristic of a sarcoma. The President, however, made a diagnosis of a sarcoma from the clinical aspects. Many of the lesions were of the so-called withering type, that is to say, coming up and disappearing without any treatment at all. The patient died about six months later from mediastinal growths, which at the time he was shown were not evident.

The President said Mr. Golding Bird had removed a sarcomatous tumour from the scrotum, and a few weeks afterwards there were a considerable number of nodules round the area. The patient was then given arsenic in the form of Fowler's solution, because at that time scarcely anything else was known for the condition. All the secondary tumours disappeared under the arsenic. The doses were very large ones, up to 30 ♏ three times a day.

(2) *A case of developing systematised nævus* on the back and front and arms in a boy, aged 8 months.

As an instance of the fallacious inculpation of vaccination it was of

some interest that the mother attributed the deformity, which was not noticeable at birth, to the effect of vaccination at three months old. The back and chest were covered with sepia-tinted wavy streaks and lines without elevation or other textural alteration of the skin. But on both hands and to a slight extent on the arms there were lines of verrucosity where the nævus had already become papillomatous. The case was shown as the exhibitor thought it might be of interest to see one of these extensive nævi in its earliest stage of development. He recalled the case shown by Dr. Garrod a few years ago in which a somewhat similar but more marked condition of pigmentation was present, but without any papillomatous development. In that case Dr. Whitfield had not diagnosed the true nature of the case when he saw it until Dr. Colcott Fox pointed out that it was an early condition of the extensive nævus.

Dr. Adamson said that some years ago he had shown a case of extensive unilateral linear nævus in an infant exactly resembling that now exhibited by Dr. Whitfield, and that although some of the linear streaks became more pronounced and more warty they eventually all disappeared. A supernumerary nipple which was present when the child was exhibited had also disappeared.

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## MANCHESTER DERMATOLOGICAL SOCIETY.

Ordinary Meeting held Friday, June 7th, Dr. R. B. Wild, the President, in the Chair.

The following cases were shown:

Dr. R. B. Wild: (1) *Primary chancre on the chin* of a girl, aged 18 years. The lesion presented was a clear-cut ulceration just above the point of the chin equal in size to a penny with hard, indurated edges.

The patient gave a history of five weeks' duration. For some time previous to this date she had been looking after her sister's baby, who was suffering from a cutaneous eruption for which it was under treatment.

When seen first by Dr. Wild two weeks previously he had had the patient tested by Wassermann's reaction, which had proved positive, although no secondary manifestations could be detected.

At the present date a faint macular eruption could be seen on the chest.

(2) *Acute Lupus erythematosus* in a woman, aged 32 years. In October, 1911, the patient first noticed a red patch on the nose. This patch first appeared during convalescence from an operation for appendicitis. She applied zam-buk to the lesion, which caused it to spread and become very inflamed, she then came to the Manchester Skin Hospital on January 27th, 1912.

*Family history.*—No history of tubercle.

She had previously suffered from measles and appendicitis.

When first seen the major portion of the face was covered with an eruption, intensely red, and of a peculiar livid colour; there was some plugging of follicles, but little, if any, atrophy. This condition improved under treatment, but in March, 1912, she had an acute outbreak, the face becoming much swollen and assuming a very livid appearance; on the hands and arms typical patches of Lupus erythematosus appeared, an erythematous rash also broke out on the chest and back. She was admitted as an in-patient. On admission she appeared very unwell, her temperature rising to 101° F.

Since admission she has made distinct improvement, her temperature having fallen to normal, and the eruption is distinctly paler. She has been treated locally with lead lotion, and internally with red iodide of mercury.

Drs. Brooke and Savatard showed (1) a case of *pyogenic granuloma*. The patient, a woman, aged 27 years, presented a circular warty lesion on the chin 4 cm. in diameter. This lesion was raised considerably above the level of the surrounding skin and infiltrated with pus, and was suggestive in appearance of a primary chancre.

Drs. Wild. Leslie Roberts and some other members expressed the opinion that the case would prove to be one of Tuberculosis verrucosa cutis.

(2) *Dermatitis herpetiformis* in a man, aged 35 years. This case had at first responded readily to arsenic, but had relapsed, and was now being treated with calcium lactate.

(3) *Dermatitis herpetiformis* in a man, aged 28 years. The peculiarities of this case were that the lesions were limited to the face and flexures.

(4) *Molluscum contagiosum* in a boy, aged 10 years. The patient presented several various-sized tumours scattered irregularly over the chest; one of these tumours, situated in close proximity to the right nipple, was of such size as to suggest that it was a Molluscum fibrosum.

(5) *A case for diagnosis.*—The patient, a man, aged 27 years.

*History.*—In April, 1911, his face, body, and limbs became inflamed and swollen. He attended at the Liverpool Skin Hospital, at which institution he was admitted as an in-patient, a diagnosis of Pityriasis rubra being made.

After four months' treatment he was discharged, the excessive desquamation having disappeared, and his general condition much improved, the skin, however, still remaining rough. In the early part of this year (1912) he had a relapse. He again attended the Liverpool Skin Hospital as an out-patient; as he became progressively worse he came to the Manchester Hospital and was admitted as an in-patient on April 18th, 1912. When admitted he had the appearance of an acute seborrhœic dermatitis, practically the whole body and all four limbs being involved. He had considerable fine branny desquamation, but was not flaking. His temperature was normal and he did not complain of itching.

He improved considerably the first week under treatment with a mild sulphur ointment, and feels quite well, although he is still suffering from a wide-spread desquamating dermatitis, which does not improve under treatment. This dermatitis is papular in character, non-follicular; the papules are flat-topped, but are very little raised above the surface, and are especially well marked on the backs of the hands. The scalp, lower extremities and trunk present islands of normal skin. On the arms the normal linear markings of the skin are much exaggerated.

The exhibitors were of the opinion that the condition was seborrhœic in origin.

Dr. Leslie Roberts thought that it was an atypical case of Lichen ruber planus. Against the latter diagnosis were the absence of itching and the usual colour associated with that condition.

(6) A *case for diagnosis* in a woman, aged 29 years.

*History.*—The first attack occurred nine years ago; since that time she has had recurrent attacks once or twice a year, the lesions disappearing totally during the intervals. The present attack began

last October, and had persisted in spite of treatment. At the present date she has several circinate desquamating lesions on the hands. These lesions are erythematous round the margin with clear centres, but show no distinct atrophic changes.

Some members thought the case was one of Erythema multiforme, whereas others regarded it as a case of Lupus erythematosus.

(7) *Syphilide in a woman*, aged 28 years.

*History.*—In August, 1911, the patient's arms became red, swollen, and very painful. She consulted her medical attendant, but the following week the redness had spread over her whole body. In September she took to her bed. In January, 1912, she had an attack of epistaxis, and she has gradually lost strength. Menstruation ceased seven months ago.

At various times she has had mercury, potassium iodide, arsenic, strychnine and iron prescribed, but in spite of treatment has got progressively worse.

On May 9th, 1912, she was admitted to hospital, having had no treatment for three months.

When admitted she presented a cachectic appearance, was very weak, and could not stand without assistance.

She presented a wide-spread eruption involving almost the whole body, papular on the back, corymbose in arrangement, papular on the extremities, with rupial crusts and large ulcerated areas. The scalp presented many bald areas, and on the face the eruption was nodular, giving it the appearance of Lupus vulgaris. Areas where resolution had taken place were intensely pigmented. The mucus surfaces were healthy and the lymphatic glands not enlarged. Sight and hearing were normal.

Since admission the patient had gained strength; she can now stand and walk alone.

On May 24th a Wassermann was taken, which proved positive.

She was given 0·6 grm. of salvarsan by the intra-muscular method, and she is now taking 30 gr. of potassium iodide daily.

Dr. G. H. Lancashire showed (1) *a case of ringworm of the nails.* The patient, a farmer's son, aged 20 years. A year ago the toe-nails became infected; most of them are now shed. Three or four months ago the finger-nails became affected.

The nails were dry and brittle, heaped-up at the free end with a firm mortary incrustation; some of the nails were fissured and the nail-beds inflamed and tender. The peculiar features of the case were:

(1) That the disease began on the feet.

(2) That every nail was affected.

Microscopic examination of scrapings showed fungus in plenty, chiefly consisting of large branching mycelium.

A cultivation was being made, which Dr. Lancashire hoped to show at a future meeting of the Society.

There was a history of ringworm in the herd of cattle on the farm where the patient worked.

(2) *Lichen planus in a man*, aged 45 years. The lesions were mainly on the legs and had persisted for some time.

(*a*) Each leg showed five or six patches of verrucose Lichen planus of ordinary appearance.

(*b*) Many follicular lesions, keratosed, plugged and linear in arrangement. There were no typical flat-topped papules. There were also a few follicular groups of papules on the trunk and a few pigmented patches.

In the region of the scapulæ there were scars surrounded by pigment, probably the result of acne.

## CURRENT LITERATURE.

**A COMPARATIVE STUDY OF DERMATITIS REPENS AND ACRO-DERMATITIS PERSTANS.** Richard L. Sutton, M.D. (*Journ. Cut. Dis.*, June, 1911, vol. xxix, No. 6, p. 325.)

Radcliffe Crocker in 1888 first described a peculiar chronic spreading dermatitis which usually followed an injury, and was characterised by the development of vesicles or bullæ, with subsequent elevation and exfoliation of the epidermis at the periphery of the lesion.

In 1897 Hallopeau reported several examples of a somewhat similar dermatitis, usually confined to the extremities, although secondary lesions sometimes developed from new foci on other parts of the body, no region being exempt. To this condition he gave the name Acrodermatites continués (Acrodermatitis perstans).

Dr. Sutton describes two cases which resemble the Dermatitis repens of Radcliffe Crocker, and one which presents the features of Hallopeau's Acro-dermatitis perstans. A careful account of the histology is given, and as regards the ætiology he is of opinion that the disorder is due to a specific organism, probably some

particular strain of the *Staphylococcus pyogenes aureus* or *albus*. He thinks the evidence sufficient to warrant the inclusion of Hallopeau's cases under the name "Dermatitis repens" first given by Radcliffe-Crocker. J. H. SEQUEIRA.

EPITHELIOMA OF THE UPPER LIP IN A PURE NEGRO. H. H. KERR, M.D., and H. H. HAZEN, M.D. (*Journ. Cut. Dis.*, June, 1911, vol. xxix, p. 321.

THE authors state that in a careful search through the literature at the Surgeon-General's Library, they have been unable to find the record of any case of epithelioma of the upper lip in a pure negro. The case described is that of a male negro, aged 57 years, a painter by trade, the entire left side of the upper and outer third of the lower lips being involved. The glands were affected. The authors comment upon the fact that cancer occurs more frequently in the white than in the negro, and find that epithelioma is very rare in the negro. It is suggested that pigmentation is protective against epitheliomatous degeneration.
J. H. SEQUEIRA.

DE LA RÉACTION DE WASSERMANN APLIQUÉE AU TRAITEMENT DE LA SYPHILIS. E. JEANSELME and A. VERNES. (*Paris Médical*, vol. i, Reprint.)

JEANSELME and Vernes have made 1526 Wassermann examinations in which they have classified their results by comparing the degree of hæmolysis with a fixed colour scale. They have eight standard tubes of different solutions of fuchsin varying from clear transparency tint 0, rising by degrees, tints 1, 2, 3 to tint 8 which corresponds to total hæmolysis. By comparison with these standards they are able to construct charts in every case illustrating the effects of treatment upon the Wassermann reaction. Fourteen characteristic charts are given.

Stress is laid upon the importance of an examination of the Wassermann reaction and of the cellular content of the cerebro-spinal fluid in cases of syphilis which are not influenced by treatment. The conclusions of the authors are as follows:

There is no therapeutic formula which can be applied indifferently to all cases of syphilis.

Treatment ought to be determined by the indication of the Wassermann reaction and of lumbar puncture.

The Wassermann reaction with the modifications suggested permits a determination of the virulence of the syphilis: its fluctuations can be followed independently of the objective manifestation and recurrences anticipated.

Observations on the composition of the cerebro-spinal fluid are important. Milk, pus, serous and synovial fluid in syphilitic subjects always give a Wassermann reaction of the same intensity as that of the blood, but the cerebro-spinal fluid is an exception being cut off from the rest of the organism. *A gross meningeal lesion is necessary for it to give a positive reaction.* Conversely if the syphilis has concentrated all its activity on the interior of the arachnoid space, a positive Wassermann of the cerebro-spinal fluid may be present with a negative reaction in the blood. J. H. SEQUEIRA.

THE ÆTIOLOGY OF LUPUS ERYTHEMATOSUS WITH ESPECIAL REFERENCE TO TUBERCULOSIS, AND A REPORT OF THIRTEEN CASES TESTED BY THE MORO REACTION. D. Friedlander, M.D. (*Journ. of Cut. Dis.*, August, 1911, vol. xxix, No. 8, p. 417.)

Dr. Friedlander gives an exhaustive *resumé* of the recent work on Lupus erythematosus, and discusses the various hypotheses advanced to explain the phenomena of the disease. He tested twelve adult cases of the discoid type and one of diffuse type with the Moro reaction, in which four positive reactions (*i. e.* on the inoculation site) occurred, all in the discoid type. Thorough physical examination failed to show any tuberculous symptoms in but one of the thirteen patients; two gave a history of family tuberculosis, but both these cases were negative to the reaction.

He concludes that the disease is not tuberculous *per se*, but the question as to whether it is due to a tuberculous or other toxin is not so clear. The disease is caused by a toxin, carried by the blood, as evidenced by the fact that the blood-vessels are the first structures to be affected, and while tuberculosis or a tuberculous inheritance may predispose to Lupus erythematosus by lowering the general resistance, it is certainly more of a predisposing than a causative factor.

That it is a constitutional affection is clearly shown in those cases which pass over into the acute fulminating type, where the patient shows all the symptoms of a profound toxæmia with involvement of various internal organs, especially the kidneys, but the cause of the toxæmia cannot be laid to any single toxin.

That feeble or deranged circulation, trauma and irritation, are factors in the causation of this affection is also evident, but whether the toxæmia precedes the local irritation and the external lesion is the exciting factor, or whether the skin damaged by the external lesion presents less resistance than the remaining cutaneous envelope to the circulating factor, is a question to be determined.

J. H. Sequeira.

THE RELATIONSHIP OF VACCINE THERAPY TO THE TREATMENT OF CERTAIN DISEASES OF THE SKIN. D. King Smith, M.D. (*Journ. of Cut. Dis.*, August, 1911, vol. xxix, No. 8, p. 432.)

*Acne.*—About 150 cases of Acne vulgaris have been under observation. These were divided into three classes, namely:

(*a*) Those due to the acne bacillus.

(*b*) Those due to the acne bacillus and the *Staphylococcus albus*, both of these organisms being present in large numbers.

(*c*) Those due to the *Staphylococcus albus*, with practically no acne bacilli present.

Clinically it is possible to associate with each of these classes a certain type of lesion. In class A the chief lesions are the comedone, papules, and papulo-pustules. In class B there are papulo-pustules and pustules, and in class C deep-seated pustules with marked scarring. There are certain cases in which these sharp lines of demarcation cannot be drawn.

For class A a vaccine of the acne bacillus was used, the dose being five millions, repeated twice a week. The results in a number of cases were good, but on the whole were disappointing.

In class B a vaccine made from the *Bacillus acnes* and the *Staphylococcus albus*

was employed, the dose being five millions of the acne bacillus and ten millions of the albus. The results were better than in class A, at least 50 per cent. showed marked improvement.

In class C a vaccine made from the *Staphylococcus albus* was used, the dose being ten millions. The results were excellent.

*Furunculosis.*—The number of cases treated was between seven and eight hundred.

The vaccine employed was prepared from eight to ten strains of the *Staphylococcus aureus*, three of the *albus*, and one of the *citreus*. The best dose was found to be about 125 millions, repeated twice weekly for three or four weeks. The results were good in 90 per cent. of the cases, marked improvement often resulting after two or three injections. If the treatment was discontinued after three or four injections, in quite a large number of cases relapses would occur, and it was found that, as a rule, at least eight or nine injections should be given.

Five per cent. of the cases did moderately well, while the remaining 5 per cent. were failures, the latter including patients suffering from diabetes, Bright's disease, and brain-fag.

*Carbuncles.*—The results were similar to those in furunculosis. It was noted that the longer the duration of the case previous to inoculation, the better was the prognosis.

*Coccogenic sycosis.*—Fifteen patients were treated. The best results were obtained in the acute cases; sometimes long-standing cases responded very rapidly, while in others the results were not very satisfactory. The dose used was 125,000,000 of the albus, given twice a week.

*Lupus vulgaris.*—In the two or three cases treated the results were disappointing. In one case marked improvement was noticed, but the patient could not be kept under treatment so as to judge of the final result.

*Erysipelas.*—The most brilliant results of vaccine therapy were seen in cases of erysipelas. Perhaps the most striking change in the patient was a rapid subsidence of such symptoms of toxæmia as mental unrest or even delirium, and of that profound malaise so usual in this disease. Locally, some spread of the process usually occurred until after the second inoculation, which, as a rule, is given the second day.

It is entirely unnecessary to prepare a vaccine for each case. It is, however, advisable to have a composite stock vaccine derived from several different strains from as many different cases. It is probable that the more virulent the case of erysipelas the more valuable will its streptococcus be as a vaccine. The method of treatment is, in almost every case, to inoculate with 250,000,000 of the devitalised streptococci on the first visit, if the case is a severe one. On the second day, in the severe cases, the patient gets another injection of 250,000,000 if there are signs of improvement.

The general rule followed is: The more severe the case and the less satisfactory the clinical response the smaller the dose.

The site of inoculation chosen has always been away from the area involved.

*Eczema.*—Over forty cases of ezcema were treated by a *Staphylococcus albus* vaccine. The type which responded best was the so-called Eczema squamosum. In many of these cases the results were excellent. Pruritus, which was marked in a large percentage of the cases, disappeared very rapidly. J. H. Sequeira.

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